Neck and Back Center

3441 PEACH ST • ERIE, PENNSYLVANIA • TEL. (814) 864-2225

000018297 Are you a New patient here? ☐ yes ☐ no ☐ I have been treated here before on __________

Date_____________ Name: First_________________ Last_________________ _Middle_____ Birth Date ___________

Address_______________________________________ City _____________ ___State _____ _Zip ____________

Home Phone_______________________ Cell Phone ____________________ Cell Phone Provider _______________

Soc. Sec. No.________________ Sex_____ Marital_________ Email Address_______________________________

How did you hear about us____________________________

Is this illness the result of: Accidents: Auto ☐ Employer ☐ State ☐ Other Type Accident Describe _______________________

Date of Injury__________________ Occupation _____________________ Height______ Weight _____ Age _______

No. of Children _______ (Female only) Are you Pregnant? ________ Last Cycle Date______________

Employer _______________________Employer's Phone __________________Address_________________________________

Have you ever been to a chiropractor before? Yes ☐ No ☐

When ___________________________ Where ___________________________

Have you ever had any surgery? Yes ☐ No ☐

If yes, please give type and date (month & year) List all surgeries.

____

____

Family Dr___________________________ Phone Number____________________

Are you presently taking medications? Yes ☐ No ☐

If yes, please give type, dosage, and what it's for below:

____

____

Are you allergic to any medications? Yes ☐ No ☐

If yes, please give type: ____

Date of Last X-Rays __________________ Where___________________________

Do you have health insurance? Yes ☐ No ☐

Check type:
☐ Medicare ☐ Auto ☐ Blue Cross/ Blue Shield
☐ Aetna ☐ Worker's Comp ☐ Health America
☐ UPMC ☐ Medicaid (type)___________ ☐ Other_______________

Describe complaints & all areas of pain.

____
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How long have you had these symptoms?

____
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____

History of previous accidents or injuries

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____

Do you have any difficulty with the following? If yes, mark "X"

☐ Headaches
☐ Shooting head pains
☐ Sinus trouble
☐ Loss of smell
☐ Hay fever
☐ Asthma
☐ Loss of taste
☐ Tightness of throat
☐ Inflammation of throat
☐ Thyroid Trouble
☐ Face Flushed
☐ Twitching of face
☐ Loss of memory
☐ Fatigue
☐ Depression
☐ Head feels too heavy
☐ Dizziness
☐ Neck Pain
☐ Fainting
☐ Loss of balance
☐ Ringing in ears
☐ Wear glasses
☐ Lights bother eyes

☐ Muscle Spasms in neck
☐ Grating in neck
☐ Tightness of shoulder muscles
☐ Neuritis in shoulders and arms
☐ Pins & needles in arms & hands
☐ Cold Hands
☐ Chest Pains
☐ Shortness of breath
☐ TB
☐ Heart pain
☐ Heart Palpitation
☐ Mid-back pain
☐ Heart attacks
☐ High blood pressure
☐ Low blood pressure
☐ Anemia
☐ Rheumatic fever
☐ Nervous stomach
☐ Stomach trouble
☐ Ulcers
☐ Nerves and nervousness
☐ Inner tension
☐ Irritability

☐ Cold sweats
☐ Liver trouble
☐ Gall bladder trouble
☐ Indigestion
☐ Intestinal gas
☐ Low back pain
☐ Constipation
☐ Kidney trouble
☐ Menstrual cramps & pain
☐ Menstrual Irregularity
☐Diabetes
☐ Cancer
☐ Sleeping Problems
☐ Painful Joints
☐ Swollen Joints
☐ Arthritis
☐ Slipped Disc
☐ Pinched nerves in back
☐ Pins & Needles in legs
☐ Swollen ankles
☐ Cold Feet
☐ Pins in legs & feet

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:__________________________ **Last Name**:__________________________

Email address: __________________________@_________________ (Please put **N/A** if you do not have E-Mail)

Preferred method of communication for patient reminders (Circle one): Email / Phone / Text
****If you want text message reminders please list your cell phone provider** ______________________

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** ___________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): __________________

- **Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

- **Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*
Enter N/A if this does not apply

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies? **Enter N/A if this does not apply **

Medication Name	Reaction	Onset Date	Additional Comments

Please read the following statement then place a ✓ in the box once read.

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date: _________________

An Assistant will take your BP
Please fill in your Height & Weight
Height: __________
Weight:__________
Blood Pressure:______ /______

For Office Use Only:
Vitals Entered all Places (*Please Initial*) _____
W. Clinical Summary_____
Patient Education ______________________________
Step 1_____________ Step 2_________________

Neck & Back Center

3441 PEACH STREET
ERIE, PA 16508
PH. (814) 864-2225
FAX (814)868-1199
E-mail: TheNeckAndBackCenter@gmail.com

RECORDS RELEASE AUTHORIZATION

Today's date: ____________________

I hereby authorize and request ______________________ to release records to:

Dr. Curtis Bannister
& Dr. Stephanie Coursen
Neck and Back Center
3441 Peach St.
Erie, PA 16508

the complete history, records, results of testing, x-ray films and reports in your possession, concerning my illness and/or treatment from__________ to present.

A PHOTO COPY OF THIS RELEASE IS AS ACCEPTABLE AS THE ORIGINAL.

______________________ ______________________

Patient Signature **Witness Signature**

______________________ ______________________

Patient Name (Print) **Date of Birth**

GENERAL CHIROPRACTIC CONSENT

DATE:_______________

Chiropractic/Physiotherapy is a proven efficacy. However, as with any health care treatment, certain risks are inherent. I hereby certify that these risks have been adequately explained to me by Dr. Stephanie Coursen and/or Dr. Curtis Bannister. I also hereby consent to any and all treatment that may be deemed necessary.

Patient Signature:_________________________________ Guardian (if under 18):_______________________

ASSIGNMENT OF BENEFITS

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment of medical benefits directly to The Neck and Back Center for services rendered. I understand that I am responsible for any amount not covered by insurance.

____ _________________________

Authorized Person Date

ASSIGNMENT FOR DIRECT PAYMENT (NON-PARTICIPATING)

If my current insurance policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows: The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtness to the assignee, and I have agreed to pay, in a current manor, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case.

____ _________________________

Authorized Person Date

MEDICARE PATIENTS

We are a Medicare participating office. Each year there is a deductible that every Medicare recipient must pay out of pocket. If you carry supplemental insurance, we will bill them as a courtesy to you. If you do not carry supplemental insurance, you will be responsible for your deductible and also the required 20% co-insurance for each visit.

____ ____________________________

Patient Signature Date

Notice of Privacy Statement

I have received a copy of The Neck & Back Center's Notice of Privacy Statement.

____ _____________________________
Patient Signature **Date**

The Neck & Back Center Chiropractic Billing Policy

- I understand copayments and coinsurances are due at the time of service.
- I understand that it is my responsibility to provide The Neck & Back Center with current, accurate billing information at the time of check in and to notify The Neck & Back Center of any changes in the information.
- I understand qualified insurance charges can be submitted to primary insurance carriers by The Neck & Back Center. I understand this is done as a **courtesy** and The Neck & Back Center will not enter into a dispute with any insurance carrier over any claim. This is ultimately my responsibility and obligation.
- I understand that The Neck & Back Center does NOT guarantee that my insurance will cover treatment.
- I understand that if my account becomes past due, it may be turned over to a collection agency. If my account is not paid in full and is turned over to a collection agency and/;or attorney, then I agree to be responsible for all reasonable fees necessary for collection of the delinquent account including, but not limited to, collection agency fees of 50% of the balance due and costs and reasonable attorney's fees or 33% of balance.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash or credit card.
- I understand that I must give advanced notice if I am not able to keep my appointment. If notice is not given, I understand that I may be charged a "no show fee" which is my responsibility, not the responsibility of my insurance company.

My signature below confirms that I have read these billing policies and understand my financial obligation.

Print Name

Signature **Date**

BILLING POLICIES

As a courtesy, The Neck and Back Center will send a claim to your insurance company. **However, you have a contract with your insurance company to pay for services you receive and on your behalf.** If for some reason your claim is not paid within 40 days of submission, you may be held responsible for payment in full. A cash payment will be expected at the time of service if your insurance company is no longer covering visits for you, or you have used all of your visits for the year.

I have received a copy of The Neck and Back Centers' Chiropractic Billing Policy

______________________________ __________________________
Patient Signature Date

Notice of Privacy Practices Statement

Dear Patient,

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY. YOUR PRIVACY IS IMPORTANT TO US.

At Neck and Back Center we are committed to providing you with the best medical care and service. While information about you is fundamental to our ability to do this, we fully recognize the importance of keeping personal and account information secure.

In order to offer you the best medical care and service, Neck and Back Center may need to share information about you both within Neck and Back Center and outside of Neck and Back Center with other medical facilities, physicians and with insurance companies. This allows us to offer you and provide you with the best medical care and services that you require to best meet your needs. We want you to understand our information safeguards, what information we collect, what information we share, and what information is necessary for us to share in order to benefit you and your medical care.

This notice describes the privacy practices of Neck and Back Center governed by the laws of Pennsylvania and the United States of America. This notice explains Neck and Back Center's information collection and sharing practices. It lets you choose whether or not Neck and Back Center may share certain information about you, either within Neck and Back Center or outside of Neck and Back Center with hospitals, physicians, and/or insurance companies.

SECURITY PROCEDURES

Neck and Back Center understands the importance of protecting and securing the privacy of your medical information and using it appropriately. Access to your medical information is restricted to Neck and Back Center and:

1. Those who assist us in providing you with medical care and treatment when appropriate (e.g. : Hospitals, other physicians involved with your care) and
2. Those who assist us in your insurance claim processing when appropriate (e.g.: Insurance Companies, Electronic Claim providers).

Neck and Back Center complies with the federal standards for the security of your medical/personal information.

When Neck and Back Center is required to share information about you with hospitals, other physicians, insurance companies, Attorneys or other, we require them to impose safeguards and to use the information only for the permitted purpose. We also limit the amount of information shared, to what is appropriate. Neck and Back Center requires anyone receiving or requesting information on your behalf to have a medical records release, signed by you or other appropriate acceptable correspondence, signed by you authorizing the release of your information. Neck and Back Center maintains an accounting disclosure list of non-routine disclosures of your medical record.

INFORMATION WE COLLECT

Neck and back center collects and uses personal information about you in order to conduct our business and to deliver to you the quality service you expect from us. Sources of information include:

- Patient Information Demographics (e.g.: Address, telephone number, social security number, date of birth, etc.)
- Patient History Information (e.g.: Past surgeries, Allergies, Medications, etc.)
- Problem History (e.g.: current medical condition)
- Personal History (e.g.: family physician, your employer, insurance carrier, etc.)

INFORMATION WE SHARE WITHIN NECK AND BACK CENTER

Neck and Back Center may need to share all of the information we collect about you with other physicians and employees within the Neck and Back Center in order to better serve your medical or financial (insurance) needs.

INFORMATION WE SHARE WITH OTEHRS

When addressing your medical care and treatment it is sometimes necessary to share your medical/personal information with hospitals and other health care providers, family members and others whose interests are also providing you with the best medical care.

When addressing your insurance claim needs it is necessary to share your medical/personal information with your insurance company in order to process your claims. In certain circumstances, such as in electronic

claim filing, your information is sent through an insurance clearinghouse that forwards the information to your insurance company.

When necessary, your medical/personal information may need to be shared with an attorney, legal and/or law enforced circumstance.

In all of these circumstances, Neck and Back Center will abide by the applicable laws protecting your medical/personal information.

OTHER INFORMATION USES AND DISCLOSURES

The following description includes examples. Not every possible use or disclosure for Treatment, Payment and Health Care Operations purposes will be listed.

Treatment: We share and discuss a patient's medical information with other practice physicians, other office medical staff involved in your care, outside physicians whom we refer or consult in your care, hospitals or surgery centers, radiology centers, home health agencies, durable medical equipment agencies or other facilities where we refer you or testing.

Payment: We share only the necessary information to submit the claims, the necessary information required by insurance companies to determine coverage eligibility and covered services, quality assurance audits, billing statements to designated family member, collection agencies, attorneys and consumer reporting agencies. (Example: your social security number is the same as your insurance company policy number)

Health Care Operations: Activities conducted to operate the practice include a patient sign in sheet in the waiting area, the paging of patients in the waiting room when it is time to go to the examining room, making calls to reschedule missed appointments, including leaving messages on answering machines or with the person answering the phone, correspondence by mail, billing statements with our name and address, and the corporation attorney for any legal issues.

INFORMATION ABOUT YOUR CHOICE

We at Neck and Back Center are dedicated to servicing your medical needs and respect your choices related to your privacy. You may choose to tell us not to share specific information related to your medical/personal information. You are entitled to a copy of our privacy practices. By submitting a written request to our office, you have the right to file a complaint with our office if you believe your privacy rights have been violated. With written authorization, and if reasonably applicable, you have the right to authorize other uses and disclosures. You have the right to inspect, amend, complete, copy and obtain an accounting of disclosures.

GENERAL INFORMATION

This information is being provided to you so that you are advised at how your medical/personal information is used. Neck and Back Center will only use your information to provide medical care and treatment, to assist you in processing your insurance claims and according to the laws established by the state of Pennsylvania and the United States of America.

The terms of this notice apply to all records containing your individual identifiable health information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your medical records that our practice created or maintained in the past or create or maintain in the future. Our practice will post a copy of our current notice in our office waiting area. You may also request a copy of our most current notice at any time. We respect your right to privacy.